ES-3822A
07-01-06

Statement of Continuing Cancer Treatment

Medical Assistance - BCC Program

Note: This form must be completed by a physician

Patient Name: _____ Date of Birth: _____

Dear Sir or Madam:

The above-named patient is currently receiving healthcare coverage under the Medicaid program. In order to determine ongoing eligibility, we must determine if the person is still receiving cancer treatment. Please complete the following information on the patient.

1. Are you currently providing cancer-related treatment for this individual? ☐ No ☐ Yes

   Yes, list type of cancer: _____

2. Describe any cancer-related treatment you are currently providing _____

_____

_____

_____

3. List any medication you have prescribed for the patient for cancer treatment, including dosage and frequency: _____

_____

_____

4. When do you expect cancer treatment to end? _____

_____

_____

Physicians Signature: _____ Date: _____

Physicians Office Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

If you have any questions, please call the Medicaid case worker,

_____ at _____